



**The Network of Ethnic Physician Organizations
The California Medical Association Foundation**

**2006
ETHNIC PHYSICIAN
LEADERSHIP SUMMIT
Report**

September 30 and October 1, 2006
Los Angeles Airport Marriott



Sponsors

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2006 Ethnic Physician Leadership Summit

Acknowledgements

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“Facing the Health Care Crisis in Diverse Communities”

Executive Summary

The 2006 Ethnic Physician Leadership Summit represented another milestone in the development of the Network of Ethnic Physician Organizations and the growing influence of its member organizations in the arenas of public policy development and organized medicine. Summit participants heard from Dr. Mark Smith, CEO of the California Healthcare Foundation, how potential solutions to the problems of health care cost escalation and suboptimal quality are likely to have a major impact on the practices of ethnic physicians. They also participated in a lively discussion of Performance Incentive Programs that involved their colleagues, researchers, and a federal official.

Summit workshops provided in-depth coverage of current issues such as the clinical implications of the role of human papillomavirus (HPV) in the development of cervical cancer, emergency response and public access, models for physician community service, and using the media to promote healthier communities.

An indicator of the growing importance of NEPO’s public policy voice was the discussion of the future of the Martin Luther King, Jr. General Hospital and Charles R. Drew Medical School. Congresswoman Maxine Waters, California Assemblyperson Mervyn M. Dymally, and Susan Kelly, Ph.D., the new President of Charles R. Drew University made a special visit to the Summit to share their insights and recommendations on the continued deliberations designed to allow the hospital to continue operations.

Whether addressing national directions in healthcare financing and quality, or critical California issues such as the future of MLK, Jr. General Hospital, or practice and community service topics, the 2006 Summit of Ethnic Physician Organizations provided a forum for provocative discussion, skills enhancement, and network strengthening among attendees.

Saturday – September 31, 2006

Opening Remarks

Frank E. Staggers, MD, Chair of the CMAF Board of Directors

In his opening remarks, Dr. Staggers discussed how NEPO is designed to galvanize and strengthen ethnic physician organizations to address the health disparities of the communities they serve. He described

how Rolland Lowe, MD, while Vice Chair of the CMA Board of Trustees, set in motion a long-range plan to get

NEPO's past and potential are linked through an ambitious vision and far-reaching strategy.
Frank E. Staggers, MD

more ethnic physicians into CMA leadership. His plan resulted in the creation of the Ethnic Medical Organizations Section and establishment of a dedicated seat for a representative of this organization on the Board of Trustees.

As Chair of the Board, Dr. Lowe helped to create a community focus in the mission of the CMAF. One of CMAF's first projects was the creation of an organization of ethnic physician organizations that paralleled EMOS. The resulting Network of Ethnic Physician Organizations (NEPO) became a focal point for ethnic physicians and their organizations to address health problems in a collaborative and community-based fashion, engage in public policy advocacy for the health of ethnic communities, and protect and strengthen the practices of ethnic physicians practicing in their communities. NEPO also became a national model for how to mentor and support students of color in their goals to become physicians.

Through the effort of Dr. Lowe and the work of the leaders of ethnic physician organizations, NEPO continues its development as a partnership based on mutual understanding, respect, and trust and as a shining example for the rest of the nation.

QISS Project Update

Doretha Williams-Flournoy, MS
Director, Network of Ethnic Physician Organizations

Cristina Correa
Project Coordinator, Network of Ethnic Physician Organizations

The Quality Improvement in Solo and Small Group Ethnic Physician Practices (QISS), funded by The California Endowment, was conceived out of concerns from Ethnic Physician Organizations about the viability of the solo and small group practice models that are an important source of access to healthcare for low-

QISS Facts

Targeted Regions:

San Diego, Los Angeles, Bay Area, and Central Valley.

Target Practices:

- Solo and small group practices (1 – 6 physicians)
- Ethnic physician practices
- Primary care practices
- Safety net providers

Primary Care Providers:

- Family practice
- General practice
- Internal medicine
- OB-Gyn
- Pediatrics

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income communities of color. These concerns are based on trends that include:

- Ethnic physicians leaving their solo and small group practices.
- Emergence of pay for performance.
- The crisis in health care, as manifested in Los Angeles.
- Reduced numbers of primary care providers.

The QISS project is conducting a needs assessment of solo and small group ethnic physician practices to document their contributions and identify the challenges they face as small businesses. The purpose of QISS is to ensure the viability of solo and small group ethnic physician practices in diverse communities. Project goals include:

- Increasing awareness of and advocacy concerning health care issues faced by ethnic physician solo and small group practices.
- Work with primary care solo and small group ethnic physician practices to improve the quality of and access to care provided to safety net communities in California.
- Increase collaboration between solo and small group practices and other community-based services.

The QISS project seeks to answer the following questions:

- How can ethnic physicians promote positive change in their communities?
- What are the major challenges facing ethnic physicians in solo and small group practices?
- How can community-based practices reach out to younger physicians?
- How can policy change enhance the effectiveness and survival of ethnic physician practices in underserved communities?

How to Support the QISS Project

- Volunteer to participate in the project's research
- Provide project staff with physician referrals and contact lists.
- Encourage physician participation in the project.

For more information about QISS, contact Christina Correa at ccorrea@cmanet.org.

The QISS Project incorporates the principals of community-based participatory research. The project's

Advisory Committee provides input and tracks project progress. The project also encourages feedback of ethnic physicians to ensure its research reflects the values and needs of ethnic physician organizations.

The QISS Project will complete its first phase, conducting focus groups, in January 2007. The second phase (March 2007 – August 2007) will consist of site visits to and surveys of target physician practices. CMAF will complete the project completion and publish its final report by January 2008.

Healthcare Financing and Delivery

“Trends in Healthcare Financing and Delivery”

Mark D. Smith, MD, MBA
President and CEO
California Healthcare Foundation

Dr. Smith reported that the U.S. health care system must address four inter-related imperatives:

- Control costs
- Improve quality
- Expand use of information technology
- Eliminate disparities

How those imperatives are addressed will have a profound effect on ethnic physician practices, especially those in solo and small group settings.

Dr. Smith put the escalation of health care costs in perspective by noting that 35 years ago, the cost of health insurance was 8-15% of the earnings of minimum wage workers depending on the state in which they were employed. Today that cost range is 86 – 101% of their earnings. This cost escalation has also resulted in increased concern by workers, consumers, employers, and governments about the costs of health care for workers and retirees, and who will bear the burden of current and future costs. Similarly, the fundamental issue in expanding insurance coverage to un- and under-insured people is who will pay the rapidly expanding costs for coverage: providers (through reduced reimbursements), consumers, employers, or government?

Unlike other industries, health care costs are increasing even as use of technology is expanding. Furthermore, some research suggests that increased expenditures may have an inverse relationship to quality of care.

Dr. Smith identified the following changes required to control costs, increase quality, increase use of technology, and reduce disparities:

1. Recognize the mismatch of the practice model with the payment model. Physician reimbursement should be for tasks that truly require physician training and judgment.
2. Commitment to quality should be prerequisite for increased healthcare funding.
3. Increase use of evidence-based practices.

California HealthCare Foundation (CHCF)

CHCF Focus

- Care of chronic disease
- Focus on underserved
- Monitor healthcare policy and markets

CHCF Resources

- California Healthline
 - Health Beat
- www.chcf.org

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4. Increase quality of care measurement and public reporting of results. Enhance health care system accountability through increased quality information dissemination.
5. Increase end-to-end automation of health care procedures to reduce the costs associated with “connecting fast cheap machines with slow expensive people.”
6. Support development of affordable medical practice technology, especially for physicians in solo and small group practices.
7. Attack disparities in health care through advocacy for improved quality of care and patient centered care along with language access and cultural competence. Do not allow promoting cultural competence to mask promoting cultural stereotypes.

“Pay for Performance: The Intersection of Quality Improvement & Health Disparities” Panel

Moderator: Elaine Batchlor, MD
Chief Medical Officer
LA Care Health Plan

Presenters: Alyna T. Chien, MD, MS
University of Chicago

Rodney G. Hood, MD
President & CEO
Multicultural Health Disparities Institute

Hector Flores, MD
Board of Directors
California Latino Medical Association

Jeff Flick
Regional Administrator
Centers for Medicare & Medicaid Services
San Francisco

Performance Incentive Programs (PIP) are growing in use by payors as a quality improvement tool. As Dr. Chien explained, PIP explicitly links rewards and/or sanctions to performance on specific measures of health care processes and/or outcomes. Monetary reimbursements provide financial incentives/sanctions; public reporting of measures affects the reputation of the health care organization or provider.

Pay-for-performance is coming. The issue is “how”, not “if”.

Jeff Flick

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While U.S. health care spending has reached about 16% of Gross Domestic Product, measures of quality of the American health care system place it near the middle of similar measures of developed countries. Mr. Flick noted that government and business payors would not continue to tolerate rapidly rising costs accompanied by mediocre health care quality. PIP is one tool, but not the only one, being developed to promote quality of health care.

PIP programs are applied to hospitals, practices and groups, and individual physicians under fee-for-service, capitation, commercial programs and programs for un- and under-insured. PIP programs are used by all types of payors, are applied to a variety of incentivized measures, and employ a variety of incentive triggers.

Collectively, the panel examined the following questions:

1. What is the relationship between improving quality and reducing health disparities?
2. Are practices of ethnic physicians, especially solo and small group, at an institutional disadvantage in current implementations of PIP?
3. What should be done to increase the appropriateness of PIP as a tool for reducing disparities, increase PIP applicability to ethnic physician practices, and to improve strengthen ethnic physician practices?

Dr. Chien reported that:

1. A review of the literature revealed that:
 - PIPs may not improve quality
 - Quality improvement does not necessarily narrow disparities
 - PIPs may widen racial/ethnic disparities
 -
2. Programs as currently designed:
 - Do not necessarily have the needs of racial & ethnic groups or disparities in mind
 - Have features that may contribute to widening disparities by inducing patient cherry-picking and rewarding providers who already have resource advantages over those serving ethnic communities.

Dr. Hood identified the following problems for practices serving ethnic communities with the manner in which PIP programs are designed and implemented:

1. Relatively lower financial reimbursements for practices with higher risk patients.
2. PIP administrative costs for small and solo practices are relatively more expensive to implement than high volume practices.
3. Group quality indicator disparities that result in part from lower baseline quality measures.
4. Incomplete encounter data that result from lack of automated data systems and measurement anomalies.
5. Unfair quality indicator comparisons.

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6. Tiered networks and physician economic profiling.
7. De facto racial and ethnic discrimination.
8. The ultimate inequity – continued worsening of health disparities.

Dr. Flores discussed PIP programs in the context of IPA he leads and identified three primary problems from the way PIP programs are currently configured:

- PIP programs are illness-oriented.
- They are technology dependent.
- They discriminate against generalists.
- Measurements do not take into account services to under insured that don't generate charges.

Panelist PIP Recommendations

Recommendations to Reform PIP:

1. Understand the patient/provider mix
2. Measure race and/or ethnicity
3. Decide “individual” versus “system”
4. Make stratified comparisons
5. Explore “disparity” measures
6. Consider risk adjustment
7. Reward improvement

Recommendations to Enhance Ethnic Physician Practice Performance under PIP:

1. Support ethnic physician investment in information technology.
2. Motivate providers around process of care.

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Martin Luther King, Jr. Hospital and Charles R. Drew Medical School Update and Outlook

- Presenters:** Susan Kelly Ph.D., FAPS
8th President, Charles R. Drew University of Medicine & Science
- Maxine Waters,
US House of Representative, 35th Congressional District of California
- Mervyn M. Dymally,
California Assembly District 52
- Jeff Flick,
Region 9 Administrator (San Francisco),
Centers for Medicaid and Medicare Services
- Hector Flores MD, California Latino Medical Association
- Ralph Di Libero MD,
President, Los Angeles County Medical Association
- Arthur Fleming MD,
Chair NEPO
- Frank Staggers MD,
Chair Board of Directors for CMAF

The continued existence and effectiveness of the Martin Luther King, Jr. Hospital and Charles R. Drew Medical School continues to be a major concern to NEPO. The participation of legislative and administrative federal and state government officials, as well as the new President of the medical school and the President of the Los Angeles County Medical Association reflected the importance of NEPO's attention to the King/Drew. Collectively, their message to Summit participants was a message of support and of cautious optimism. Dr. Kelly indicated that while the accreditation crisis of the hospital does not directly threaten the continued existence of Charles R. Drew, the medical school does need for the hospital to remain operational to provide a practice setting for university students. Ms. Waters described the current Los Angeles proposal to allow the hospital to operate under the license of UCLA as the best chance to meet federal Medicare accreditation standards.

“Update on Network of Ethnic Physician Organizations Strategic Plan”

Wilma J. Wooten, MD, MPH

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Dr. Wooten, Chair of the NEPO Strategic Planning Team, presented the NEPO Strategic Plan for 2006 – 2010. She noted that NEPO is an organization of ethnically diverse organizations and that its complexity requires a strategic approach to its management and development.

Highlights of the NEPO Strategic Plan 2006 – 2010		
Guiding Principles		
<p><i>NEPO will:</i></p> <ol style="list-style-type: none"> 1. Work together in a manner that enables our members to share our ideas, listen to one another and build trust. 2. Enable ethnic physicians to grow in their understanding of the cultural and language needs of our member communities. 3. Empower ethnic physicians to bring about positive change in the health of their communities. 4. Take appropriate action together for our patients and communities. 5. Include a focus on prevention and wellness. 		
Strategic Initiatives	Core Values	Core Competencies
<ul style="list-style-type: none"> • Progressive, Thriving EMOS • Transforming Healthcare • Optimal Health and Wellness 	<ul style="list-style-type: none"> • Collaboration • Access • Respect • Equality • Diversity 	<ul style="list-style-type: none"> • Leadership • Education • Communications • Policy • Corporate Capacity
<p>For more information about the Strategic Plan and planning process, visit: http://www.ethnicphysicians.org/</p>		

A New View of the Complexion of the California Physician Workforce: Preliminary Data from the CA Medical Board Survey

Kevin Grumbach, MD
UCSF Department of Family and Community Medicine

Health planning in California has been hampered by the lack of definitive information about the number of California’s physician population. Reports from the California Medical Association and University of California, San Francisco were in conflict over the existence of a physician shortage in California. These reports highlighted potential problems with the validity of the AMA Master File in counting the number of active physicians in the state as well as the ethnic distribution of those physicians. In 2001, the California Legislature passed the CMA sponsored AB 1586 that required the Medical

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Board to implement a survey of physicians linked to re-licensure to gather information on the “training and practice characteristics for each physician licensed in California.”

The survey included both required and optional items. Required items addressed practice characteristics including:

- Weekly hours in patient care, research, etc
- Practice zip code (if in patient care)
- Training status
- Self-designated specialties
- Board certification

Optional items included:

- Ethnic background (with 28 options and allowance of multiple selections)
- Foreign language fluency (with 34 options)

The initial survey database includes responses from about 50% of California’s 92,062 physicians with active licenses. About 82% of respondents reported their ethnicity including 3.6% who reported multiple ethnicities.

The analysis of the reported ethnicities of Asian physicians showed the largest numbers were Chinese, Indian, Filipino, and Korean. Chinese and Korean physicians tended to be graduates of U.S. medical schools while Indian and Filipino physicians were much more likely to be graduates of non-U.S. medical schools.

Ethnicity Summary		
Ethnicity	%	#
White	65.6	40,591
African American	3.1	1,949
Asian/PI	28.4	17,557
Native American / Alaska Native	1.1	351
Latino	5.5	3,248
Other	4.4	1,372

The largest number of Latino physicians reported their national origin as Mexico, followed by South America, Central America, and Cuba and Puerto Rico. Most Latino physicians of Mexican origin were educated in U.S. medical schools, while South American physicians were educated in non-U.S. medical schools.

Dr. Grumbach summarized a study that demonstrates the kinds of questions that can be addressed by this new physician data. The study examined if the likelihood of practice in underserved community of a South Asian physician was related to whether he/she was trained in the U.S. or internationally. The physician database showed that internationally trained physicians were more likely to practice in underserved communities.

Dr. Grumbach discussed historical trends in the enrollment of under-represented minority students (URM) in medical schools, nationally and in California and Texas. He pointed out that in California and Texas, enrollment gains were lost with the passage of Proposition 209 and related laws and court decisions in the mid-1990s. Texas has shown

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some recovery. However, recent national policies, including proposed drastic reductions in HCOP and COE funding, are threatening diversity programs.

Dr. Grumbach described the Programs in Medical Education (PRIME) being instituted by the University of California as a promising practice to that expands medical school enrollment while attracting students with life experiences that prepare them for leadership and service to disadvantaged populations.

In summary, Dr. Grumbach discussed how the Medical Board survey data provides an unprecedented ability to understand the ethnic profile of California physicians including more accurate measurement of overall patterns and trends by major ethnic groups and to explore variation within major ethnic groups (e.g., Asian, Latino). He also encouraged physicians to complete the surveys, report ethnicity and language information, and the development of funding and infrastructure to track and analyze California physician workforce data.

“Hot Topics in Health Policy” – Panel Presentation

Moderator: Lenny Martinez, MD
Practicing Physician
Member NEPO Summit Planning Committee

Presenters: Mitchell Katz, MD
Director of Health & County Health Officer
San Francisco Department of Public Health

Edward A. Chow, M.D.,
Executive Director
Chinese Community Health Care Association

Satinder Swaroop, M.D., FACP, FACC, FASCI
President Elect Orange County Medical Association
Vice Chair, Network of Ethnic Physician Organization Steering
Committee

Immigrant Health Challenges in San Francisco

Mitchell Katz, MD
Director of Health & County Health Officer
San Francisco Department of Public Health

Dr. Katz reported on two innovative outreach efforts to address health needs of immigrant populations.

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San Francisco has the highest incidence rate of tuberculosis of any metropolitan area in the United States, but the lowest in San Francisco history. San Francisco's TB rate reflects the large numbers of immigrants coming to the city from TB endemic areas in Asia where public health resources are insufficient to control TB. Tuberculosis in immigrants presents special challenges, including:

- Cultural and language barriers.
- Higher rates of drug resistance and multi drug-resistant TB.
- Delays in diagnosis due to poverty, lack of health insurance, and fear of medical bills.
- Undocumented persons risk deportation during TB treatment.

Dr. Katz reported that San Francisco has priority to targeted testing and preventive treatment for the foreign born including:

- Individuals with old scarring on chest radiographs
- Persons with latent TB infections (although with normal chest x-rays)

San Francisco has also adopted special approaches for addressing TB in immigrants, including:

- Hiring health workers from the same cultural and language groups as the immigrants.
- Taking an attitude of high clinical suspicion and rapidly testing for drug susceptibility (with a 24-hour turnaround).
- Establishing a TB screening program in China town with ongoing outreach to the community.

Dr. Katz also described the *Jornaleros Unidos con el Pueblo (Day Laborers United with the Community)* Program established by the San Francisco Program on Health, Equity, and Sustainability (SPHES) to improve the working conditions for the immigrant day laborer community. The program is a partnership of SPHES, immigrant day laborers, and community service organizations that provides:

- Vocational skills for safety on the job.
- The Workers United Course that cultivates day laborer leaders.
- Information on cleaning with safety and dignity.
- An economic hazard feasibility study.
- The Unidos Community Council.

Dr. Katz pointed out that San Francisco is a refugee sanctuary and does not collect immigration status as a condition for services.

Maintaining Healthcare Access to Underserved Communities

Edward A. Chow, M.D.,
Executive Director
Chinese Community Health Care Association

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Dr. Chow presented information on an ongoing situation that threatened the viability of the Chinese Community Health Care Association (CCHCA). CCHCA is a non-profit mutual benefit association of 170 private practice physicians and 2 clinics affiliated with Chinese Hospital with 77 PCPs and 45 specialties. Its mission is to:

- Deliver quality culturally appropriate and affordable care to the Chinese community of SF and Bay Area.
- Provide care for indigent and needy.
- Provide and support health education in the community.

CCHCA provides commercial health plans, senior plans, and third party administration for Chinese Hospital and its own Blue Cross of California products.

Chinese Hospital is a 54-bed community hospital in San Francisco Chinatown owned by 16 community organizations. It exists primarily to deliver quality health care in a cost-effective way, responsive to the community's ethnic and cultural uniqueness, providing access to all socioeconomic levels. Established initially in 1899 as an outpatient clinic to bring western medicine to the Chinese community of San Francisco, it is today the hub of an integrated delivery system with a community hospital, health plan, and medical group.

Dr. Chow reported how today's changing market place puts CCHCA at risk. A large San Francisco based medical group (AB) decided on a strategy of exclusivity for 'select' providers to meet FTC requirements to be able to contract as a group for a PPO rate. (AB has 1500+ MDs, over 80% of non Kaiser managed care market in SF Bay Area serving over 200,000 enrollees and does not provide services to safety net plans.)

As a condition for participation in AB, 'select' providers must resign from all other IPAs and similar affiliations.

The challenge to CCHCA resulted from AB's offer of 'select' status to more than 50 of CCHCA physicians, who are also major primary and specialty (OB,GYN) providers for CCHCA. The exclusivity provision would devastate the ability of CCHCA to continue to provide coverage for its contracts, including CCHP and its safety net patients through the San Francisco Health Plan (SFHP). This would disrupt care for at least 15,000 enrollees. AB does not participate in SFHP, or CCHP (which is the Chinese Hospital integrated system), thus increasing the burden on the safety net.

Given that the loss of physician/medical services would disrupt care for this community, the Chinese Hospital Board rallied support from President of the San Francisco Board of Supervisors. As a result, the City Attorney is alerted and files suit against AB and the Board of Supervisors passes a resolution against disruption of services to community by the AB business plan. The SF Health Commission also passes a resolution supporting the Chinese Hospital health system as a public good.

This case study provides an example of the increased risk of ethnic physician organizations, which often lack the market clout of their larger competitors.

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Medi-Medi & Managed Care

Satinder Swaroop MD, FACP, FACC, FASCI

President Elect Orange County Medical Association

Vice Chair, Network of Ethnic Physician Organization Steering Committee

Dr. Swaroop reported on a successful advocacy effort by the Orange County Medical Association (OCMA) to address plans of CalOptima and the federal Center for Medicare and Medicaid Services (CMS) to move the majority of “Medi-Medi” beneficiaries in Orange County into OneCare, a managed care plan that precludes physician choice for many members. Dr. Swaroop that CalOptima intended to use passive enrollment to generate desired levels of enrollment, employed very short implementation time frames, and did not consult with physicians about the design of the program or communication with affected patients. In addition, patient-informing material that discussed the benefits of the new program failed to explain the benefits of the fee-for-service program.

OCMA developed an advocacy strategy that targeted the default enrollment policy. The key elements of the strategy included:

1. Advocacy with CalOptima, CMS, and Congress in opposition of default enrollment.
2. Coordination with the CMA.
3. Educated physicians to discuss issue with their patients and provided them with communication tools in Spanish and Vietnamese.
4. Several physician meetings with CalOptima.
5. Established a CalOptima Advisory Committee to meet on a regular basis with CalOptima staff.
6. Use Vietnamese language media to communicate with Vietnamese patients.

The advocacy effort resulted in creating a three-month transition period for the program and in doubling the number of contracted physician organizations. Because of the delay in program implementation and the aggressive education of patients, OneCare’s current enrollment is 7,800 rather than the desired 40,000. The advocacy campaign also resulted in a change in the relationship between OCMA and CalOptima that increased communication and collaboration.

Dr. Swaroop made the following recommendations to other county medical associations:

1. Be prepared – OCMA’s experience will be repeated in other counties in California.
2. Physicians should start communicating with their patients on this issue as early as possible.
3. County medical associations should develop friendly and ongoing relationships with the area CMS personnel. Ask in advance for the opportunity to review and provide input on communications to patients that market new health plan options.

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4. Physicians must keep up to date on Medicare issues by being active members of the AMA, CMA and their local medical associations and follow-up on any actions that these groups recommend.

Sunday – October 1, 2006

The Intersection of Cultural Beliefs and Health

Taking a Spiritual History

F = Faith and belief – “Do you consider yourself spiritual or religious?” “What gives your life meaning?”

I = Importance – “What importance does your faith or belief have in your life?” “What role do your beliefs play in your health?”

C = Community – “Are you part of a spiritual or religious community, and how are they of importance to you?”

A = Address in Care – “How would you like me to address these issues in your health care?”

Martin F. Bennett
Principal, Bennett Consulting

Mr. Bennett observed that physicians frequently are challenged by the need to provide high quality health care when they and their patients have different values and belief systems about the transitions that accompany health, illness, birth, and death. These values and beliefs are often influenced by culture, age, and, for immigrants, their length of time in the United States. They are also deeply influenced by, and in turn influence, religious and spiritual beliefs.

Culture is the integrated patterns of human behavior that include language, thoughts, communications, actions, customs, beliefs, values, and/or institutions of racial, ethnic, religious, and/or social groups.

Mr. Bennett

identified a number of trends that increase the need for physicians to understand the role of culture and spirituality in medical care:

- Increased numbers of immigrants and first generation workers.
- An aging population.
- Increased civil rights violations or disputes.
- Globalization of health risks.
- Global exchange of information.

Providing high quality cross-cultural health care requires an assessment of both cultural group patterns and individual variations within a cultural group and the building of partnerships based on trusting, respectful, and responsible relationships between health care providers, patients, their families, and the communities.

Mr. Bennett noted that successful cross-cultural interactions in a health care setting began with the physician understanding his or her personal cultural and spiritual framework and the framework of his/her practice by addressing questions such as:

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- Does religion and spirituality have any place in my practice? Should the expression of religion and spirituality be discouraged, allowed but limited, or strongly encouraged in all of its manifestations?
- How do I work with others who have different religious and spiritual inspired health care traditions and behaviors?
- How should religious and spiritual inspired healthcare traditions build the success of my organization?

Mr. Bennett suggested to physicians that a successful strategy to strengthen cross-cultural healthcare should address:

- Religious and spiritual cultural knowledge including the health related sacred beliefs and values of patients; the role of their own religious and cultural beliefs in your approach to health, illness, healing, and death; and, how to gain and understanding of beliefs and behaviors that are totally different from their own.
- Social skills that include communicating with others they consider to be different; mastery of the core social skills of their own culture; mastery of the basic social skills of another religious or spiritual culture; and, ability to switch styles.
- The vision of the organization including how to use their religious and spiritual orientation to work better in their organization; understanding how their religious and spiritual profile adds value to the organization; and, what steps to take to create an inclusive work environment that acknowledges and maximizes the positive aspect of all religious and spiritual diversity.

Workshops

Quality Improvement in the Treatment of Cervical Cancer

Moderator: Elissa K. Maas, MPH
Vice President of Programs, CMA Foundation

Presenter: Diana E. Ramos, MD, MPH
Director, Maternal Health & Family Planning Programs
Los Angeles County Department of Health Services

According to the American Cancer Society, there were 10,370 new cases of cervical cancer and 3,710 deaths from the disease in 2005. About half of the women who die from cervical cancer each year have never had a Pap test. As with many diseases, there are ethnic and racial disparities in the incidence of cervical cancers. Incidence rates for African American women and Hispanic women are 1.5 times those of white women and

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non-Hispanic women, respectively. In addition, there is considerable disparity among Asian population subgroups. In general, immigrant women have higher mortality rates from cervical cancer than U.S. born women.

Cervical cancer is caused by the human papillomavirus (HPV), a common sexually transmitted infection. About 20 million people are infected with HPV, with an estimated 6.2 million new genital HPV infections occurring each year. Most sexually active adults (ages 15 to 49) will acquire HPV at some time in their lives and will never even know it. Although cervical cancer is caused by HPV, the virus does not always cause disease and is usually asymptomatic.

Dr. Ramos' presentation was divided into three segments:

- The Science of Human Papilloma Virus (HPV)
- Clinical Approaches to HPV
- HPV Treatment and the Future

Part I: Science of HPV –

There are over 100 types of HPV:

- 30-40 anogenital
- 15-20 oncogenic types
- HPV Types #16 and #18 linked to 67% of cervical cancer

HPV is transmitted through:

- Sexual contact including:
 - Sexual intercourse (includes anal)
 - Genital-genital; anal-genital; oral-genital
 - Genital HPV transmission – herpes
- Non-Sexual contact including:
 - Mother to newborn (vertical transmission – rare)
 - Fomites (e.g., gloves, underwear, biopsy) (Hypothesized, but not well documented)

HPV & Anogenital Warts

- HPV Types #6 and #11 most often associated with genital warts (found in > 90% in 1 study)
- The peak prevalence period for women is ages 20-24; for men, ages 25-29.
- Infective – if exposed, 75% chance of getting genital warts.
- Genital warts may be invisible to the naked eye.
- May become severe and disfiguring.
- In men, feel for “little bumps” then examine.

Genital HPV is very common with an estimated 20 million people currently infected. There are 6.2 million new infections annually and 80% of sexually active people have had HPV. The vast majority is asymptomatic.

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The American Cancer Society and American College of Gynecologists and Obstetricians recommends HPV screening about 3 years after onset of vaginal intercourse, but no later than 21 years of age. Conventional PAP screening is recommended annually for women under age 30.

Dr. Ramos urged physicians and other health professionals to examine how comfortable they are in personally and professionally talking about sex. They should be aware of their own reluctance or bias and how it may influence their communications with patients about HPV/cervical cancer. They also need to take into consideration how different cultural mores influence transmission, acquisition, screening, and treatment decisions; Need to be educated about cultural milieu of patients

Dr. Ramos noted that cervical cancer is a marker for healthcare disparities as it's primarily a disease of women of color.

Facts about Cervical Cancer in US

- Over 95% caused by HPV; HPV Types #16 & #18 account for est. 70%.
- The number of cervical cancer deaths has decreased by 75% as a result of PAP screening.
- Over 10,000 new cases ear year; 14,000 deaths.
- Incidence rate is 8.3%.
- Highest incidence rate occurs among Vietnamese women 43/100,000 women .
- Incidence rate 15/100,000 or higher among Alaskan Native, Korean, and Hispanic women.
- Half of the women w/newly diagnosed invasive cervical cancers have never had a PAP test.
- 10% have not had a Pap test in past 5 yrs.

Part II: Addressing a Positive HPV Result

Dr. Ramos reported that patients diagnosed with HPV may exhibit the following psychosocial responses: anger, depression, isolation, fear of rejection, shame, guilt, anxiety, loss of sexual interest, and fears about cancer.

She noted that 12 months later, these feelings were still there in over 40% of patients.

Dr. Ramos made the following suggestions for educating patients:

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- Inform patients that HPV is an infection, not a disease.
- Inform women that those who smoke are at greatest risk of HPV.
- Understand the common questions patients have:
 - What is HPV?
 - How did I get it?
 - How do I get rid of it?
 - Does it mean I have cancer?
 - How do I lower my risk?
 - Why didn't I hear about it before?
- Use caution in use of language. Note that "HPV" and "HIV" sound similar, especially to limited English proficient patients and their families.

Dr. Ramos identified the following as persons who are at-risk:

- Women who have not had Pap tests.
- Women with immune problems (e.g., using steroid medications, transplant recipients, those receiving chemotherapy, HIV patients).
- Women who smoke.

Part III: Treatment Issues

Dr. Ramos also discussed the HPV vaccine that is now available. She emphasized that the vaccine is not a replacement for Pap tests, but is an adjunct. She also noted that the vaccine is not universally available through health insurance and has a cost of about \$220 for the series of 3 injections required for maximum effectiveness.

Even women with abnormal Pap smears should still be immunized. If there are no venereal warts, the vaccine is recommended; if venereal warts are present, the vaccine is not indicated.

The vaccine is expected to have a number of positive impacts:

- reduce incidence of abnormal Paps.
- reduce cost of subsequent work ups.
- reduce occurrence of genital warts and costs of treatment.
- (eventually) reduce cervical cancer deaths.

Educate Medical Office Staff

Physicians should educate their office staff on how to communicate with patients about HPV. For example, when office staff called a patient with screening results and said "...HPV positive, pre-cancerous lesions...." the patient heard "Cancer," and never heard the rest.

How can patients lower their risk of contracting HPV?

- delay onset of sexual activity
- know your sex partner
- don't smoke
- maintain a healthy diet and lifestyle
- practice "safe sex"

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Emergency Response & Language Access Seminar

Moderator: Arthur W. Fleming, MD, FACS, FCCP
Chair, Network of Ethnic Physician Organization Steering Committee

Presenters: Brian Johnston, MD
White Memorial Hospital

Lisa D. Benton, MD, MPH
General Surgeon, Stanford University Hospital
Public Health Medical Officer,
California Department of Health Services

Michelle (Shelley) B. Rodrigues, CAE
Deputy Executive Vice President
California Academy of Family Physicians

NEPO members were profoundly moved by the impact of Hurricane Katrina and the 9/11 attacks on vulnerable communities, including immigrants with limited-English proficiency. They recognize the important role that physicians can play in encouraging community emergency preparedness, providing medical care in a disaster environment, and communicating information to communities about health risks and needed protective action.

Dr. Brian Johnston's presentation addressed how disasters, such as Katrina, manifest their own racial and ethnic disparities both in the quality of the response to communities of color and in response outcomes. He urged emergency preparedness efforts to take into account language and cultural differences and to recognize the cultural alienation experienced by people in diverse communities.

Dr. Lisa D. Benton reported on the expected consequences and plans for responding to a pandemic influenza outbreak. She discussed the potential impact of a pandemic on the economy, health care, public safety, food supply, transportation and utility infrastructure, and the fabric of society.

She described the steps public health officials will recommend to reduce exposure. These steps include:

- Personal protection (respiratory hygiene, masks).
- Isolation (confinement) of ill persons.
- Quarantine of exposed persons.
- Community-based containment (canceling mass events, closing schools, closing malls and other businesses, changing transportation patterns).
- Organization-based containment (reducing contacts through teleconferencing and other social distancing strategies, implementing human resources policies that encourage ill and exposed persons to stay at home).

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Government responders and health care facilities will be faced with a surge of ill and frightened patients seeking vaccines, treatment, and information. These response institutions will need to manage this surge by:

- Coordinating their response.
- Establishing alternate facilities to handle overflow patient levels.
- Managing equipment, pharmaceuticals, medical supplies and personal protective equipment.
- Ensuring supporting infrastructure (utilities, HVAC) remains operational.
- Augmenting personnel by redirecting staff from lower priority activities, encouraging volunteers, and re-enlisting retirees.
- Harnessing community based organizations.

Dr. Benton also discussed the lessons learned from Katrina about the impact of disasters on physicians who may:

- Experience depression, anxiety, insomnia, and post traumatic stress disorder.
- Not have access to needed medications or refills.
- Need increased support for their offices.
- Be unable to assist patients.
- Have reimbursement delayed.

Ms. Rodrigues addressed two critical issues in her presentation:

- Language access is important during the medical response to emergencies as well as for medical care in a normal environment.
- Physicians need to undertake business continuity planning for their offices to minimize loss and increase their opportunity for rapid recovery.

She reported on a project undertaken by the California Academy of Family Physicians that addressed language access in physician practices. The project included a training program using curriculum developed by a team led by Alice Hm Chen, MD, MPH. The training was developed to assist physicians and their office staffs in addressing the issues faced with limited English proficiency patients including risk assessment, patient language identification, use of interpreters (trained and untrained), new technologies, payment resources, and more.

Ms. Rodrigues reported on “Preparing Your Office and Home”, a new curriculum, and monograph to assist CAFP members to assess the disaster preparedness of their offices and homes. Based on the experiences of our colleagues in Orleans Parish, Louisiana, the curriculum includes a series of articles in *California Family Physician*, Academy in Action, www.familydocs.org and incorporates the remarks of Jeffrey Runge, MD, Homeland Security who was the keynote speaker at the 2007 Annual Scientific Assembly

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The CFPA preparedness program recommended to participants that they develop a Business Disaster Kit that includes:

- Copies of all of the organizations' insurance records with contact names and numbers.
- Log-in information for bank accounts, credit card companies, etc.
- Latest financial statements.
- Investment records.
- Payroll records, including accrued vacation and sick time.
- Key contacts with cell phone numbers and email addresses.
- Checks, DEMOSit slips, letterhead/envelopes.
- Printed copy of all email addresses from work and home computers.
- Critical phone numbers, like the local health department, FEMA, SBA, etc.
- Copy of employment agreements and personnel manual.
- One or more disposable cameras.

Ms. Rodrigues also reported on the Bioterrorism and Public Health Emergency Recognition and Response Program that is a partnership among California's Area Health Education Council (AHEC) programs, the California Poison Control System, and CAFP. The mission of the program is to prepare California's health professionals caring for the state's multicultural underserved to rapidly and effectively respond to terrorism and other public health emergencies

Each of the five AHECs with California Preparedness Education Network (Cal-Pen) projects were invited to participate in the project to work with their affiliated residency programs to plan and conduct collaborative planning and training in their respective communities. CAFP sponsored the train-the-trainer sessions, and provided grants to the residency program that participated.

The four-module curriculum developed by cal-PEN addresses an all hazards approach in assisting health care professionals to:

- Recognize the risks and indications of terrorist events or public health emergencies;
- Meet the immediate care needs of patients;
- Alert appropriate authorities; and
- Participate in a response.

Twenty-three California residency program sites participated in the project over the course of 7 months, with each site conducting the full program of four modules. On average each module had 20 attendees with a total of 2,125 participants in this program, 929 of whom were reported family physicians.

cal-Pen website: <http://161.58.103.51/calpen/>

In concluding, Ms. Rodrigues noted that:

- Cultural/linguistic proficiency is important for day-to-day practice, but becomes even more so during times of emergency or disaster.

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- Physicians need to be prepared for emergencies and disasters – at home, in the office, and in the community.

Media Training Workshop: “Using Public Access Media to Reach Your Audience”

Moderator: Doretha Williams-Flournoy
Director, Network of Ethnic Physician Organizations
CMA Foundation

Presenters: Sandy Close
CEO, New America Media

Tanh Hoang (Randall) Pham, MD
Chair, Ethnic Medical Organization Section
California Medical Association

Rodney G. Hood, MD, President & CEO
Multicultural Health Disparities Institute (MHDI)
Past President National Medical Association (NMA)

According to the 2003 California Field Poll, physicians are the most trusted messengers regarding health issues. Traditionally, physicians have served as credible spokespersons to the media, policy makers, and opinion leaders. This is especially the case in ethnic communities, especially Latino and African American, where physicians have a high level of credibility and bring a critical and persuasive voice in addressing health issues in the public arena. NEPO members have prioritized media training as a strategy to increase ethnic physician utilization of the media to improve community health and reduce disparities.

Sandy Close provided workshop participants with 10 tips for working with ethnic media. She reported that there is no silver bullet for getting on the news media’s radar. Nevertheless, there are distinctive advantages in working with ethnic media. Above all, these media are committed to their communities. Most exist to provide their audiences with the news and information they need to survive in American society, and to give voice to otherwise voiceless communities. If you can position your “news” as relevant to the everyday lives and concerns of ethnic media audiences, you are a step ahead. She recommended that physicians should:

1. Find out the ethnic media news organizations in their area and develop relationships with them. (Access NAM’s national directory for starters at <http://news.ncmonline.com/directory>.)
2. Once they establish relations with ethnic media practitioners, they should communicate with them on an ongoing basis, not just when they have news to pitch, e.g. find out who covers immigration issues for the ethnic media.

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3. Target the event, story or news release to specific ethnic media audiences. Decode generic information (statistics, studies, etc.) whenever possible to make it relevant to individual ethnic communities. Ask yourself, “Why should this matter to the target audience?”
4. Find ways to partner with and engage ethnic media practitioners in their work. Ethnic Media are in many ways like community based organizations with a mandate to publicize. Ask ethnic media what they need from the physician’s organization.
5. Create opportunities for ethnic media to access decision makers and experts in the issue areas the physician works on. Teleconference calls, newsmaker briefings, roundtable exchanges that solicit ethnic media perspectives work well.
6. Don’t rely on emails alone to communicate with ethnic media. Use the phone and the fax. Be high touch, not high tech. Determine their publication or on-air schedules to know the best time to reach them.
7. Cross the language barrier and provide translations whenever possible.
8. Wherever possible, customize your messages to a “news you can use” format. Remember that ethnic media provide a consumer’s guide to audiences trying to navigate in an alien culture, and customize stories to that format.
9. Provide ethnic media with a list of the physician’s own staff experts whom they can call when they need information on the issues you cover. Find representatives from their communities who could illustrate important issues.
10. Include ethnic media at events and highlight their role in the physician organization and community’s communications. Do not make ethnic media communications an afterthought.

During the discussion following her presentation, Ms. Close recommended that New America Media serve as a broker for getting ethnic media content via radio, TV, print, Internet into ethnic media. Participants were asked to give their names and contact info to follow-up on developing this relationship.

She also suggested that NEPO develop a web-based communication vehicle like MedScape or California Healthline to get health info about ethnic communities into the public.

Dr. Randall Pham discussed the strategy he employed to establish a radio talk show for his ethnic physician organization. His step-by-step approach included:

1. Conduct a needs assessment of your community. Survey your community and your organization members.
2. Assess the resources you have available. Consider funding, personnel, time, and existing radio programs and health education programs.
3. Select a radio station for the program. Consider station popularity, availability of air time, cost per show, station track record, and other programs that are aired on the station.
4. Negotiate a contract with the station that covers start date, renewal, copyright issues, and other conditions (e.g., free announcements of health fairs, free

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- interviews, etc.). Also decide if your contractual relationship with the station should be short-term or long-term.
5. Be ethical in your approach. Do not try to profit from the radio show; do not self-advertise. Avoid controversial issues. Make full disclosure of financial interests in drugs, products, and treatments discussed on the show.
 6. Design the radio talk show including its own air schedule, whether it is live or pre-recorded, the topics it covers, speakers and other guests, and radio show format (interview, presentation, guest speaker, etc.). Focus on early planning and ensuring continuity.
 7. Maintain the program over time. Establish an organizing committee and seek ongoing funding sources. Establish a partnership with organizations such as the American Heart Association, American Cancer Society, and the CMA Foundation). Continuously assess the need for the show and its effectiveness.

Dr. Rodney G. Hood presented information on the history and format of his show on KURS Radio - The Soul of San Diego. KURS was established by the visionary Pastor Timothy Winters of Bayview Baptist Church and started broadcasting approximately 2 years ago. The station broadcasts gospel music and has a faith directed format.

KURS has expanded its programming to include a call-in student and college education program, community-talk show, and health information show. The station broadcasts 24 hours per day seven days per week in San Diego and surrounding counties as well as Tijuana. Its internet broadcasts have listeners as far away as Iraq.

Dr. Hood's program, "Your Good Health", is a health information radio program that informs and educates the public on pertinent health issues and needs that of individuals and their communities. "Your Good Health" is a one hour show broadcast weekly. The show has a medical host and invited guests and highlights medical community expertise with local medical experts. The show discusses general health topics with a focus on minority health issues.

"Your Good Health" is sponsored by local community clinics such as Careview Medical Group, practicing physicians, Multicultural IPA, San Diego Research, and local pharmacies, hospitals and organizations such as AARP. Sponsorship by the San Diego Health Department is pending.

Physicians for Health Communities Obesity Training Workshop

Moderator: Christine Maulhardt
Director, Physicians for Health Communities
CMA Foundation

Presenters: Dexter Louie, MD, JD
Chinese Community Health Care Association

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Melanie Hall, Marketing Manager
California 5 A Day Retailer Program
Cancer Prevention and Nutrition Section
California Department of Health Services

5 A Day Campaign

Melanie Hall

Over the past twenty years, obesity rates have risen dramatically, creating a public health crisis. Nationally, the incidence of obesity is higher among African Americans, Latinos, and underserved, low-income populations. The American Medical Association, California Medical Association, American Academy of Pediatrics, and Institute of Medicine have all urged an increased role for physicians in addressing the obesity epidemic. Indeed, the results of a 2003 Field Poll conducted by The California Endowment reported that nearly 90% of patients want their physicians to discuss nutrition and physical activity matters with them.

Melanie Hall reported on the strategy and activities of the California 5 a Day Campaign and discussed with participants steps ethnic physicians could take to help their patients increase their consumption of fresh fruits and vegetables and increase their level of physical activity. The Campaign is designed to:

- Reduce the risk of chronic diseases such as cancer, heart disease, type 2 diabetes, hypertension, and overweight and obesity.
- Empower low-income Californians to eat the recommended amounts of fruits and vegetables and engage in physical activity every day.
- Encourage the use of nutrition assistance programs, such as food stamps, among those who are eligible.

The Campaign employs a social marketing approach that is consumer-focused and employs the traditional elements of advertising, public relations, promotion and personal sales. The program targets low-income Californians, especially ethnic populations, and the retailers that serve and businesses that employ low-income Californians. The Campaign also promotes evidence-based practices by employing literature reviews, focus groups, key informant interviews, and surveys during the design phase and extensive process and impact evaluation of pilot tests to ensure effectiveness.

The 5 a Day Campaign established distinct African American and Latino Campaigns to implement community and culture specific strategies for low-income members of these communities. This campaign work through the respective cultural institutions of the two communities, focused marketing materials with culturally appropriate healthy foods and preparation methods, and provides material in the language and with images that resonate with the target community.

Ms. Hall discussed a number of barriers to adopting healthier practices, including how misinformation about spinach, folic acid, and other healthy foods and indicators can

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reduce motivation. She pointed out how consumers frequently struggle to make sense of all the nutritional options, claims and counterclaims, and recommendations they face in the marketplace.

Physicians can play a significant role in encouraging healthy nutrition and physical activity in the clinical setting, even with the limited time they have available with patients. Physicians are an important and trusted source of information for ethnic communities. Ms. Hall recommended that physicians:

- Stress the importance of nutrition and physical activity.
- Use appropriate language.
- Distribute culturally appropriate nutrition education materials.
- Know the community you work with and the resources available to your patients.

She also recommended making referrals to the dietician available to your practice and plan. It is also important that physicians meet periodically with the dietician to determine which questions to ask your patients and to determine if the dietician is receiving information that the physician should know about.

Ms. Hall also urged physicians to:

- Adopt and/or adapt the Campaign's messages for their patients and implement the Campaign's Toolbox for Community Education, which includes nutrition, physical activity, and community empowerment lessons.
- Volunteer as an expert health spokesperson.
- Work with community groups to educate policy makers on the importance of building healthier environments to improve health disparities.
- Build strategic partnerships with private, nonprofit, and public sectors agencies to remove barriers to a healthy lifestyle.
- Keep the issues in front of opinion shapers, the media, and decision-makers.

More than BMIs: Connecting with Students – The Next Generation of (Obese) Parents

Dexter Louie, MD, JD

Dr. Louie shared his experience with and recommendations for working with school students to promote healthy nutrition. He noted that ethnic physicians bring to the spokesperson role credibility and cultural competence. He estimates that he spends about 12 – 24 hours per year and that working with schools allows him to combine his commitment to clinical care with a preventive, public health role.

- The key features of his approach are:
- The volunteer community physician is a partner.
- A school site champion is essential.
- Students must be involved as active participants.

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- Students must take responsibility and ownership.

Dr. Louie emphasized the importance of “Site Champions” who help to introduce the volunteer to school administrators and faculty and assist with navigating school rules, regulations, and culture. He also provided suggestions for engaging students and obtaining their buy-in including the need for students to lead any on-campus nutrition campaign and write about it in the school newspaper.

He also pointed out that change takes time and reaching 25% of the students he talks with is a major success.

Closing Session

Moderator: Elissa Maas, MPH
Vice President of Programs
California Medical Association Foundation

The Summit’s closing session provided participants with the opportunity to reflect on the preceding days’ activities. Their comments reflected an appreciation for the quality of the information presented by speakers and the depth of the discussions it generated. They also recognized the relevance of the topics addressed in this Summit to their practices and to the communities they served. Generally attendees expressed an interest in continuing the discussion of pay for performance. More time needs to be spent on this issue and how it could impact physicians serving diverse and underserved communities.

The value of the Summit was not, however, limited to presentations and policy. Comments during the Closing Session revealed how important the recognition and social activities are in building cross-cultural understanding and personal relationships among participants. There was a clear call for continuing the Summit traditions of recognizing the inspirational achievements of ethnic physicians, providing cultural entertainment, and facilitating social networking. Many Participants were deeply moved by Dr. Carlos Sanchez’ presentation about his medical missions to Peru and expressed their desire to participate in a medical mission as well.

Closing Session participants made several recommendations for the next Summit. Several recommended encouraging attendance by medical students. Attendees felt it was critical to have medical students in attendance because they are the future. We need to be building relationships with the students and their organizations. It was recommended that future Summits address pipeline and other workforce issues important to them. Other suggested topics included continued focus on the MLK, Jr. Hospital crisis and exploring end-of-life and other bio-ethics issues.

Contact Information

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